

1959

# William T. Marsh v. Dr. Paul A. Pemberton : Brief of Appellant

Utah Supreme Court

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IN THE SUPREME COURT  
OF THE STATE OF UTAH

FILED

AUG 4 - 1939

WILLIAM T. MARSH,  
*Plaintiff and Appellant,*

vs.

DR. PAUL A. PEMBERTON,  
*Defendant and Respondent.*

Clerk, Supreme Court, Utah

Case No. 9041

APPELLANT'S BRIEF

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# IN THE SUPREME COURT OF THE STATE OF UTAH

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WILLIAM T. MARSH,

*Plaintiff and Appellant,*

vs.

DR. PAUL A. PEMBERTON,

*Defendant and Respondent.*

Case No. 9041.

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## APPELLANT'S BRIEF

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### NATURE OF THE CASE

This suit was brought by the appellant, William T. Marsh, against the respondent, Dr. Paul A. Pemberton, to recover damages resulting from the negligent treatment and care of the appellant in connection with the performance of a triple arthrodesis on appellant's left foot, and it was further claimed and proved by the appellant that the respondent was negligent in the post-operative treatment of appellant's condition. Respondent's negligence consisted in applying the cast too tightly without making adequate provision for anticipated swelling causing impairment of circulation, in delaying

to split the cast and remove it to relieve the continuing impairment, and in failing to take appropriate corrective measures during the post-operative care. As a result of the negligence of the respondent, appellant suffered permanent injury and disability in his left foot.

At the conclusion of the evidence, the respondent moved the court for a directed verdict which was later amended to be a motion for involuntary dismissal with prejudice, and the court granted the motion, from which order of the trial court this appeal has been taken by the appellant.

## STATEMENT OF FACTS

For convenience the appellant will hereafter in this brief be referred to as the plaintiff and the respondent will be designated as the defendant.

Inasmuch as the ruling of the trial court was grounded upon a claimed insufficiency of evidence to establish the negligence of the defendant, we shall set forth in summary for the convenience of the court the testimony of the lay witnesses and of the doctors showing such negligence.

As a guide to the court in considering the evidence, we desire to point out at the outset that the tightness of the cast caused the necrosis, or death of some of the tissues in the foot, and damage to the mechanism of the foot, and that the five cardinal danger signals of impairment of circulation as described by the defendant are: (1) pain; (2) swelling; (3) color of the toes—bluish or

dark red; (4) inability to move the toes; and (5) numbness in the toes. (R. 136, 164, 165, 166, 171, 172, 173, 174)

The operation performed on the plaintiff by the defendant was a triple arthrodesis, which means a fusing of the three joints in the foot. (R. 113)

William T. Marsh, the plaintiff, a young married man 23 years of age, injured his left foot in a skiing accident several years ago. He consulted a Dr. VanSicklin about a year after the accident, who surgically removed a chip of bone from the foot. The plaintiff, after the operation, developed arthritic complications in his foot.

On May 17, 1954, he first consulted Dr. Pemberton. (R. 23) Dr. Pemberton took x-rays and examined the plaintiff and told him if he wanted to live a normal life and be able to work and hunt and fish and do everything he had done before without pain whatsoever that he would need an operation. The operation was described as a simple one which would require casting for about three months, and after that the plaintiff would be as good as new. He was admitted to the St. Mark's Hospital on December 18, (Ex. 1 and 2) and operated on the morning of December 20, 1954.

When he first woke up from the operation his ankle was "awfully painful." (R. 29) The pain stayed about the same right at first, but started to increase after a while. He first noticed this the night of the operation, or the next morning. He made frequent complaints to the nurses. The morning following the operation, he continued to have pain in his ankle and it was greater than

the afternoon before. He complained quite often to the nurses about the pain for the reason that the other fellows in his ward didn't seem to be having as much pain as he was having, yet as far as he knew they had had the same nature of operation. He noticed on the afternoon following the operation that his toes, extending out of the end of the cast, started swelling up and turned a little reddish-blue, and on the following morning his toes were more swollen and turned bluer in color. One of the interns was in there every two or three hours, and the nurses were in and out quite often. (R. 30-31) Usually after a hypo he would go to sleep for two or three hours and upon awakening he would still have the same pain in his foot as before the hypo. (R. 32)

The day following the operation he was conscious most of the day, but still had a great deal of pain all of the time. His toes were swollen and a bit different in color, and his toes were numb. (R. 33) The numbness continued throughout his stay in the hospital and the swelling and discoloration of the toes increased on each day following the operation. Dr. Lamb, at 6:30 in the morning on the 22nd day of December, examined his toes and squeezed them and inquired if plaintiff could feel anything. Plaintiff said no, and either Dr. Lamb or his associate took a needle and pricked his big toe and he could not feel it, and that is when they decided to split the cast, at least they were talking about it then. The doctor asked him about the pain he was having and plaintiff described it as a bursting feeling like a lot of pressure was building up inside of the cast, pushing out. The pain was greater than it had been the evening before. It was a steady pain.

It was about two hours later when they came back in to split the cast. (R. 34-35) (Ex. 1) When the cast was split, it popped open like there was an awful lot of pressure inside. They opened up maybe an inch and a half down toward the ankle. The splitting of the cast somewhat relieved the pain at first and it relieved the awful pressure, although plaintiff continued to have pain after that all of the time. The cast was opened wide enough to expose the area where the incision had been made. (R. 36)

He was confined to his bed throughout his stay at the hospital, but on the last day was fitted with crutches. At the time of his discharge, he still had pain in his foot, but felt pretty good other than that. He told Dr. Pember-ton that he still had pain in his foot and had had all of the time. He was told that pain was to be expected for a while after an operation of that kind. (R. 37-38) Upon arriving at home, he walked on crutches into the house and went right to bed. He had been instructed to stay in bed a few more days with his foot elevated. He carried out the instructions. Two weeks later he went up to the defendant's office and his cast was taken right off and another cast put back on. (R. 39) The whole foot looked awfully dark in color. On his previous operation performed by Dr. VanSickle, the incision appeared normal to him, but in this case there was some darkness of the foot. It was a brownish color. He was told to report back in two weeks. (R. 40) On the occasion of his next visit about two weeks later, the cast was again taken off, the bandage removed and there was a big, gaping wound. His foot had turned darker in color—almost black. The wound looked like it was deteriorated and was



draining a little pus. (R. 41) There was an odor when the cast was taken off. He asked the doctor if it was natural for his foot to look like that, and he would just say a few words, but nothing pertaining to it. The doctor gave no explanation for the condition. The doctor cut some dead tissue away, dressed the wound, and put another cast on. He took no x-ray pictures, nor did he manipulate the leg. (R. 42) The leg or foot remained painful all of the time, a dull, aching pain. There was a little sensation in his toes. Plaintiff was told to stay off his foot and continue with crutches which he did. He never departed from the instructions. He returned two weeks later. A bad odor developed about the cast. (R. 43) On that occasion the cast was changed again, a new dressing applied to the wound and more tissue cut away from it. The wound was still open with dead tissue around it. It was pretty much the same. When he asked the doctor about it, he got the same answer as before. (R. 44) The doctor just didn't seem to want to talk to him about it. The plaintiff was told to remain off his foot. He saw the doctor again in another couple of weeks. The odor was still present. (R. 45)

The cast was changed on the plaintiff's leg about four or five times at intervals of about two weeks apart. Plaintiff was on crutches for about six months, although he had originally expected to be on them for three months. He carried out the doctor's instructions relative to not bearing weight on his foot, and finally in July of 1955, accompanied by his father, he called on the defendant and while he was seated just outside of the door his father asked the doctor what was wrong and why his foot was

in its then condition. "And the doctor didn't say too much." *Plaintiff's father asked if it could have been that the original cast got put on too tight and he (the defendant) said "it could have been."* (R. 47) At that time he was bearing weight on his foot, having been instructed to do so about two weeks previous, and the bone was sticking down through the bottom of his foot and the shoe would rub where the open wound was, and it was awfully hard to walk. He continued to have trouble bearing weight on his foot. It was like having a marble in his shoe and trying to walk on it. His toes were clawed and they would rub on the top of his shoe and would get sore. (R. 48) The plaintiff exhibited his foot to the jury, showing the clawing of the toes, the scarring of the soft tissue in the area of the incision, and the callus on the bottom of the foot where the bone protruded, which prior to the trial, of course, had been operated upon by Dr. Okleberry. (R. 49-50)

Dr. Okleberry cut some of the bony prominence off the bottom where the bone was sticking down, which somewhat improved his ability to bear weight on his foot. (R. 52) Notwithstanding the corrective operation by Dr. Okleberry, the plaintiff still has clawing of the toes, which rub the top of his shoe and get sore and callused, and the bottom of his foot where the bony prominence is sore all of the time when he is walking on it. Every step is painful. The more he walks on it, the more painful it gets. (R. 54) The plaintiff is limited in athletics and hunting and fishing. The left leg has become smaller than his right leg. (R. 55) He is unable to dance,

suffers mental anguish because of being limited in the use of his left lower extremity. (R. 56)

M. Thirl Marsh, the father of the plaintiff described the boy's condition previous to the Pemberton operation as giving the plaintiff some discomfort, but not a great deal. He also participated in about everything, had a heavy schedule in basketball and played regularly, although he complained sometimes after the games that his foot was tired. (R. 94) Prior to the operation, the witness visited with Dr. Pemberton in November of 1954. He told the doctor that the boy was not in serious trouble and he asked the doctor if there was any danger of complications from the operation. The doctor said it is not likely, that he had performed these operations quite often, had done many of them, and considered it a very simple one, that it was painful, but not of long duration. He said there was nothing to worry about.

The witness called on his son the evening following the operation on December 20th, and he was very much aware that the plaintiff was in considerable pain. He called on the plaintiff the following day late in the afternoon. The plaintiff complained that his pain was very severe. The witness noted the perspiration on the plaintiff's forehead. The toes protruding from the end of the cast were badly swollen and were a little dark and off color. (R. 97-98-99)

The toes on December 21st were swollen and dark. (R. 100) He called the afternoon of the day the cast was split and noted that the toes were still off color. (R. 101)

He was still suffering from pain on that day. (R 101) On two or three occasions during the post-operative treatment the witness visited with the doctor and inquired how the plaintiff was getting along, to which the doctor replied: "We are doing all we can. He is all right."

In the latter part of June or the first of July, the witness asked for a definite appointment with the defendant and had a 15 or 20 minute conference with him. (R. 103) During the conversation, he told the doctor point blank that they were very much concerned and that things weren't going well, and asked him why. And the defendant stated that complications had developed that he hadn't anticipated. The witness said: "Could that be the result—could this unsatisfactory condition be the result of the cast being placed on the leg too tight?" And he defendant said: "Yes, it could be." (R. 104) At the time of this last visit with Dr. Pemberton the witness described the wound as being exceptionally large and not healing well. There was a prominent protrusion through the bottom of the plaintiff's foot. During the month of May, the defendant advised the plaintiff to throw his crutches away and start walking on the foot. After the plaintiff began walking on his foot, it caused a lot of discomfort and there was a definite protrusion through the bottom of the foot. (R. 105) The witness noted a definite protrusion—"a knob" on the bottom of the foot before any callus or sore developed. (R. 106)

Mrs. Mary Marsh, mother to the plaintiff, testified that when they first called on Dr. Pemberton in May of 1954 he said it would not be a serious operation, but would

be painful. He said there wouldn't be any risk at all. It would be in a cast for a while, but after it was taken off he would be able to live a normal life, like any young boy. (R. 77-78)

She was in the ward when the plaintiff was returned from the operating room just before noon. (R. 80) She remained at the hospital on the day of the operation until 8:00 o'clock in the evening. Several times during the first day she felt his toes and they were swollen, but the plaintiff reported on feeling. The plaintiff complained continuously of terrific pain, and the witness asked the doctor if something could be done, and he said they were doing all they could. There was a little bit of red discoloration on the day of the operation and there was swelling of the toes. (R. 81) She saw him about 2:30 o'clock in the afternoon of the 21st. At that time he was complaining of pain, perspiration was standing out on his forehead. He was nauseated and complained that he didn't feel well. He said there was no feeling in his big toe. He also complained quite strongly about the pain, so the witness went to the nurse several times and asked if they could not do something, and they said they had given him a hypo, or would give him a hypo, and that is as far as it went. His toes were still discolored on the afternoon of the 21st and swollen. (R. 82)

She next visited the hospital on the 22nd in the afternoon, after the cast had been split. The toes were bluish and swollen. The patient still complained of pain, and his toes were still bluish in color on the 23rd (R. 83-84) There was still no noticeable change on the day of dis-

charge, over the previous day. They were instructed to return in two weeks to the doctor.

The witness went with the plaintiff on January 3rd. The patient was suffering a lot of pain. (R. 85) The pain was severe. He required pain pills every night so that he could sleep and was also given pain pills during the day. (R. 86)

On one of the visits when we asked the defendant what was causing the condition in the leg the defendant did not answer he just shook his head. (R. 88)

She knows of no occasion when the doctor's instructions were ever violated. (R. 89) At the time plaintiff stopped calling on the defendant, the witness described the flesh on his foot as having turned black. He was told that he could throw away his crutches and try to walk on his foot, and it was then that the bone in his foot dropped down. It was like walking on golf ball. (R. 90)

Exhibit 1, consisting of the hospital records, contained a note from the doctor on the operative record to the effect that the patient's condition was good throughout the operation. The hospital record showed that at 1:15 p.m. on December 20th (the day of the operation) the plaintiff complained of severe pain and thereafter hypos were given at approximately three hour intervals for pain.

The first notation of a visit by a doctor was 10:45 p.m. on December 20th. At midnight on the evening of the operation he complained of pain in the leg. Hypo was

given at midnight, and at 3:00 a.m. to relieve pain. Patient slept some, but was awake most of the night. At 8:15 and 11:50 a.m. hypos were given for pain. At 9:00 p.m. on December 21st, plaintiff's toes appeared quite red and somewhat swollen. The edges of the cast were snipped to relieve pressure. Hypo was given for pain at 10:00 p.m. At midnight he was awake, complaining of pain, and on December 22, 1954, at 1:15 a.m. he was given a hypo for pain. At 6:30 a.m. he complained of pain and sedative was given. Dr. Lamb was present. Dr. Lamb examined left toes—quite swollen—states he has no sense of feeling present. 8:30 a.m. a hypo is given for pain and the cast split open by Dr. Lamb to relieve pressure. Toes were blue color. Received some relief after opening of cast. However, at 12:15 p.m. another hypo was given for pain. At 2:45 he was able to move toes a little better and to feel better in the toes. At 6:00 a.m. on December 22nd the intern noted that the toes appeared to be cyanosed and swollen. At 12:25 a.m. on December 23rd he was given hypo for pain. At 7:00 a.m. he was given a hypo for pain and his left foot was still quite swollen and dark looking. Dr. Pemberton and Dr. Lamb visited and at 11:00 a.m. another hypo was given for pain. Plaintiff stated his cast felt extremely tight against the ankle area. At 2:15 another hypo given for pain. At 5:15 he was complaining of pain in left ankle, toes still swollen. At 5:55 hypo was given for pain. At 9:15 hypos were given for pain. Sedative was given. On December 24, 1954, at 12:15 a.m. hypo was given for pain. At 4:00 a.m. hypo was given for leg pain. Toes were edematous and swollen. The final notation in the nurse's record at 6:00 a.m. states that there was less edema in the toes, discoloration re-

mains about the same, unable to move toes much. Dr. Pemberton and Dr. Lamb visited. Discharged per wheel chair. (Ex. 1)

## DEFENDANT, DR. PEMBERTON

The defendant testified with respect to his training and qualifications as a specialist in the field of orthopedics. (R. 110-114) He noted that padding is required over bony prominences to keep the plaster from rubbing against the bone at the side of the ankle, for instance, and padding is required to allow for swelling after bone surgery. (R. 115) Padding is important because it allows space for swelling to occur and prevents friction of the cast. The padding is placed over the entire extremity to be covered by the cast, more padding being placed in the area where surgery is performed because swelling usually occurs at that point to the greatest degree.

“Q. What is going to eventuate in the event that there was an inadequate amount of padding; as swelling occurred what would be the result?

A. Excessive pressure on the soft tissues within the cast, which would result in impairment of circulation (R. 118), impairment of nutrition and increased pain.

Q. Now, why would impairment of circulation occur?

A. Because as it swells against an immovable layer, we will call the plaster, it gets tighter, and that tightness eventually will reach a point where it compresses the blood vessels, and compression of the blood vessels, of



course, has the result of impairment of circulation."

\* \* \*

- A. If the pressure is adequate it can stop the venous return of the blood from returning, but it cannot stop the arterial blood from going in." (R. 119)

*The swelling increases the pressure and the pressure increases the impairment so that both work against each other.*

"Mr. White: *And where the initial impairment occurs, because of excessive swelling or inadequate padding, or whatever the cause, when the initial impairment occurs it would then have a tendency, would it not, to become worse?*

"The Witness: Yes."

\* \* \*

- "Q. Now, when this impairment occurs to the point where it prevents the return of the blood through the veins, does that propose any threat to the soft tissues of the body in the area which is involved?

\* \* \*

- A. Yes.

- Q. What would you say that the nature of the threat be?

- A. As the circulation is impaired nutrition of the tissues is impaired.

- Q. What do you mean by that?

- A. The blood gives up oxygen and food to the cells.

- Q. What happens to the cells when that occurs?

- A. They die. That occurs after a long enough period.

Q. How long can the cells be deprived of nutrition and continue to live?

A. It varies with different types of tissue. \* \* \* In general, in an extremity we don't feel there is any impairment, as far as life is concerned, by leaving a tourniquet on for two or three hours." (R. 121.)

After three hours of impairment tissue death begins to occur. (R. 122) The stitching of the wound made during the operative procedure in itself slows down circulation. (R. 127) An adequate blood supply is necessary for healing, and an adequate blood supply is necessary to prevent infection.

"Q. So that a good, fresh supply, an uninterrupted supply of blood to the area where the incision has been made and where sutures have been put into it, is important to protect against infection?

A. That is right.

Q. And as that supply of blood is decreased the threat of infection increases? (R. 128)

A. That is right.

Q. And if infection takes place, that slows down healing; is that correct?

A. Yes.

Q. If infection takes place, that may also add to necrosis?

A. Yes. (Necrosis means death of tissue)

\* \* \*

Q. Now, as a matter of fact, tissues will most certainly die if they are deprived of a sufficient supply of blood?

- A. Yes. (R. 129)
- Q. I mean that is one of the things that you have in mind when you perform surgery, is to permit healing and to prevent infection, and do all of the other things that are necessary for an uninterrupted supply of blood to that area; is that correct?
- A. That is right.
- Q. Now, you have described yesterday how you put the casts on after arthrodesis. You put the padding on first?
- A. Yes.
- Q. And the reason for the padding is because you contemplate swelling?
- A. That is right.
- Q. And in the arthrodesis situation the swelling is greater than in other situations, is it not?
- A. Greater than in some others, yes. (R. 130)
- Q. Tell me this: You do expect extensive swelling in a triple arthrodesis operation?
- A. Yes.
- Q. Where will that swelling occur?
- A. About the wound.
- Q. Will you indicate on your own foot where that swelling would occur?
- A. The operation is done across the outside of the foot, as you saw on Mr. Marsh; the swelling will occur first about the wound, and because of that swelling and consequent destruction of soft tissues, and the skin itself having a limit to its elasticity, therefore some impairment of the circulation distal this part,

so there would be expected some swelling beyond that point.

Q. So there would be some swelling on the toes?

A. That is right.

Q. Of the point below where the swelling occurs in the wound?

A. Yes.

Q. And that is because of a certain amount of impairment of circulation?

A. Yes.

Q. And you, of course, know that always occurs in the triple arthrodesis situation?

A. Yes.

Q. And that is one of the reasons for using padding?

A. That is right.

Q. Before applying the plaster cast?

A. Yes." (R. 132)

The witness testified that swelling will compress the padding so that it is no longer soft and flexible, and it becomes relatively useless as a padding, and that sometimes happens, so that the padding becomes ineffectual to permit the free flow of blood to the area of the wound. (R. 134)

"Q. Now, Doctor, after a triple arthrodesis is performed and the cast is in place—let's assume it is placed on properly, and the padding is put on properly, is it ever necessary to pay any attention to that lower extremity post-operatively?

A. Yes, it certainly is.

Q. Why?

A. Because we know that swelling is going to occur, and we don't know the extent of it—it varies in different patients. So we watch to see whether our judgment has been right in regard to the amount of padding. We watch the circulation and the evidence that we can see. We leave the toes out so that we can see them. It is necessary to determine from various signs and symptoms whether or not our judgment has been right, as to the amount of padding, the position of the foot, and the circulation in the foot.

Q. Now, this swelling, Doctor, actually starts immediately after the operation is concluded, does it not?

A. Yes.

Q. For that reason I take it you can not just look at him after the first hour and after the second hour after operation and not look at it any more; isn't that correct?

A. That is true.

Q. So that you maintain a careful post-operative examination until the cast is actually removed, do you not?

A. Yes.

Q. Now, the reason, or one of the reasons for leaving the toes exposed is that it is beneficial to have something (R. 135) to look at to determine whether or not this impairment of circulation is occurring?

A. Yes.

Q. In other words, the cast prevents you from seeing the area of the swelling itself?

A. That is true.

Q. What signs of a decrease in blood supply or impairment of circulation are afforded by the toes?

A. The amount of swelling, color, temperature, and subsequently the ability to move the toes and the sensation in the toes.

Q. You have swelling as Number One?

A. I believe that was number one.

Q. Now, you have swelling of the toes anyway, without impairment. There is a certain amount of impairment necessitated by the operation, is there not?

A. Yes.

Q. That causes a certain amount of swelling of the toes?

A. Yes.

Q. But if the swelling of the toes—if there is a considerable swelling in the toes, that is something over the ordinary, then you take that as a sign?

A. Yes.

Q. Then the color of the toes?

A. Yes.

Q. What color are the toes when the circulation is normal?

A. Pink." (R. 136)

The witness testified evasively about the significance of numbness as a sign of impairment of circulation between pages 152 and 145 of the record, claiming that in some instances numbness is due to a severing of the

nerves during the operative procedure rather than to impairment of circulation. In the instant case, the witness had no recollection of having severed any nerves, and if he had known if any nerves were severed it would have appeared in the operative record. (R. 145-146)

“Mr. White: Doctor Pemberton, if you have numbness in the toes, you know there are two possibilities for the numbness, do you not? (R. 146)

“The Witness: Yes.

Q. Severance of the nerves or impairment of circulation?

A. Yes.

Q. The more probable of the two possibilities is impairment of circulation, is it not?

A. If the numbness is present from the time of the operation when first the patient is conscious, then we can presume it is due to severance of the nerves. If it develops and increases and was known to be not present before, we can presume it was to circulation. If there be some numbness immediately after the operation and it increases, and after release as in this case of what we considered to be building up too much pressure, that to some extent it was due to impairment of circulation. Also I can not say there were no cut nerves; we can not do that because it may have been both.

Q. All right. In the instant case did you make an examination of the plaintiff's toes to determine if there was any numbness after the operation was performed?

A. Not immediately.

Q. When did you make the first examination after that?

A. I can not recall." (R. 147)

The defendant operated on three boys the very same morning, and they were all three in the same ward together. (R. 153) The defendant claimed that he saw the plaintiff at least twice in the afternoon, although the hospital record does not show it, and the doctor's visit usually appears in the hospital record. (R. 147-148) The reasons that he remembers visiting the patient, notwithstanding the failure of the record to note it, is that he had operated on two other patients the same morning who were placed in the same ward, (R. 149) although there was no indication in the record of his visit to the other patients, and he only remembers it because it was his practice to do that. He had no actual independent recollection of having made such a call. (R. 154) He operated on the first patient at about 7:45 in the morning, and on Bill Marsh around 9:00, and the third operation around 10:30. (R. 156)

The defendant made no test for numbness of the toes on the day of the operation, (R. 161-162) although he described numbness as one of the five cardinal signs of impairment of circulation. (R. 164) That any one of the five cardinal signs of decrease in blood supply can even be observed by a nurse. (R. 164) *Each one of the five cardinal signs of impairment of circulation is individually important.* (R. 165) Excessive swelling is probably the most important as it tends to promote additional impairment, and in the beginning if impairment the first



indication is swelling. (R.166) A tourniquet is used during the surgery and although the witness testified that the blood supply may be completely cut off without damage for three hours, he stated that in his practice they would release the tourniquet probably every hour or hour and a half to permit blood to go through and revitalize the tissues. (R.167) The most common practice on the part of orthopedic surgeons in this area is to release the tourniquet every hour and a half. (R.169) (It is not claimed that defendant left the tourniquet on too long. This simply shows the importance of maintaining blood supply without more than one and a half hours of suspension.)

“Q. So it helps you a little bit to have something besides swelling, doesn't it, to determine whether or not there is actually a dangerous decrease in the blood supply?

A. I don't think I follow you there. Put it this way, if this answers your question: If these other signs show up it gives additional awareness, yes.

Q. Well, Doctor, you always expect swelling?

A. Yes.

Q. Now, the swelling has to become unusual in order to give you warning, doesn't it?

A. Yes.

Q. So that before the swelling becomes unusual in this type of case may some of the other signs be present?

A. Yes.

Q. Then without regard to consideration of swelling, they are of some importance in determining what color the toes are?

- A. Yes.
- Q. And there is some importance in determining the amount of numbness?
- A. Yes.
- Q. Or the extent of it?
- A. Yes.
- Q. And whether numbness occurs, based on the time of operation and of sufficient area that you can eliminate the possibility that it was due to severed nerves rather than due to the impairment of circulation?
- A. Yes.
- Q. And it is important to determine whether or not there is loss of motion?
- A. Yes.
- Q. So as you said before, each one of those five things is of individual importance?
- A. Yes.
- Q. *And as an orthopedic surgeon practicing your profession here in Salt Lake City, with all of your experience and the many operations you have performed, you would want to avail yourself of each and every one of those five cardinal symptoms if they were present?*
- A. Yes.
- Q. *And I take it that you would want to do so just as soon as any one of those five cardinal symptoms could be discovered?*
- A. Yes.
- Q. And I take it that is one of the reasons why you train your nurses in the hospital, and your interns, when they make their visits,

and your associates, and why you yourself are trained; that is one of the reasons that you train them to look for each one of those five cardinal symptoms?

A. Yes.

Q. As soon as the patient is available for them to look at him?

A. Yes.

Q. So that if Bill Marsh was returned to his room and his bed at 11:45 on the day of the operation, it was important to determine whether each of those five symptoms are present?

A. Insofar as possible, yes.

Q. Now, when would it be necessary, in the proper practice of your profession in this area, to make a second check.

A. Assuming that he had gotten it the first day, the second check would be made on the following day—the day after the operation.

Q. In other words, if at 11:45 when he is returned to his room none of these five symptoms are apparent, you can wait until the next day to look again?

A. No; I say that assuming that he got through the first day, he would be checked again that afternoon.

Q. By whom?

A. By me or one of my associates, the nurses or the interns.

Q. Well, then, as a matter of fact, you did, as I recall, check him that afternoon twice?

A. Yes.

- Q. But on neither occasion did you concern yourself with the numbness in his toes?
- A. That is right.
- Q. When did you first concern yourself with the numbness in his toes?
- A. On the following day.
- Q. What time in the following day?
- A. Probably in the morning, when I saw him, early.
- Q. Now, are you again relying upon your memory, or do you have an office record of some kind on that?
- A. I believe it is in the hospital record.
- Q. Well, let's find it. Find it for me.
- A. December 21. He was operated on the 20th. Doctor Lamb notes 'Numbness in toes. Circulation good.' " (R. 171, 172, 173, 174)

The witness admitted that he did not feel the patient's toes on the day following the operation and that he did not recall asking the plaintiff about it. (R. 176) Although numbness was one of the five signs of inadequate circulation, the witness stated that it wasn't necessary for him to determine what the explanation of the numbness of the toes was. (R. 177)

- “Q. But in this particular case the impairment of circulation did continue from the time the operation was performed until the cast was actually split two days after the operation. isn't that true?
- A. I believe that to be true, yes, sir. (R. 178)
- Q. Was there anything in the hospital record up to the time of your first visit to the effect that he was complaining of severe pain?

- A. Yes; I believe the nurse said that. I would have to see the record.
- Q. Well, she used the very word "severe", didn't she?
- A. I would not say precisely. The patient complains a lot when pain starts.
- Q. Now, the first notation on the hospital record — you watch it with me, Doctor, so that I will be quoting it right. At 11:50 — no, at 1:15 of the first day — he has been in his room now for about an hour and a half?
- A. Yes.
- Q. 'Complaining of severe pain.'
- A. Yes, sir.
- Q. Now, the next indication of pain is on December 21st; is that midnight?
- A. Yes.
- Q. On that same day?
- A. Yes.
- Q. 'Hypo. Complaining of pain in leg. Hypo given for pain. Sleeping quietly for a short time.' And then at three o'clock, three hours later: 'Hypo repeated.'
- A. Yes.
- Q. I assume the nurse repeated the hypo under instructions that she had, and that was because he was still complaining of pain at that time?
- A. That is right.
- Q. Now, when you made your visit on this following day, it probably would have been in the morning, would it not?

A. Yes. (R. 179-180)

Normally pain would tend to decrease after the second day. (R. 183)

Q. The usual and most frequent situation is that the pain might be increased say to include the second day, but beyond that it would start to decline?

A. I would expect so, yes sir.

Q. Now, as an orthopedic surgeon practicing your profession in Salt Lake City, Doctor, and alert for those cardinal symptoms of pain and others, you would want to concern yourself with the amount of pain, so far as you could, that the patient was suffering?

A. Yes.

Q. Even on the first day after the operation?

A. Yes.

Q. And more especially the second day?

A. Yes. (R. 184)

Q. The nurse's record say, Doctor Pemberton: 'Sleeping quietly for a short time,' in between hypos here at midnight and three A. M., and 'slept some. Awake most of night.' Did that give you concern that his pain was of such character, that it had no significance with respect to the five signs we have been talking about?

A. I would say it had no alarming significance. That is about ordinary after major operations, what the pains would be. We don't expect a patient to sleep well the first night.

Q. You expect him to be awake most of the night?

- A. Yes.
- Q. Well, when can you start to use this sign of pain?
- A. It is one of the signs that we take into consideration from the beginning.
- Q. Well now, Doctor, why say that, when you just got through telling us that they are always under such pain that they can not sleep for the first night; why do you say you can take pain into account under those circumstances?
- A. Because with seventy-five milligrams of demerol the man went to sleep; if he didn't sleep at all with one hundred milligrams of demerol I would seriously consider something was wrong; but the man slept in the usual manner with the usual amount of analgesic.
- Q. Slept fitfully?
- A. Very probably; I don't know what the record shows in regard to that.
- Q. I do know; I have seen the record.
- A. Well, fitfully, yes.
- Q. He was awake most of the night?
- A. Yes.
- Q. Slept for a little time?
- A. Yes.
- Q. During the time he was awake he was complaining of severe pains?
- A. Yes. (R. 188-189)
- Q. When you checked the patient in this case he was a big strapping boy of about 190 pounds, and he said his pain was severe. Did

you question him about that; did you talk it over with him at all, to see how severe, or have him describe it to you? (R. 189)

A. I don't recall that I did.

Q. Did you ask him if it was a throbbing or pressing or unremitting type of pain?

A. No.

Q. What kind of pain follows impairment of circulation, if you know?

A. I don't believe there is a characteristic type of pain; it is just a severe pain.

Q. Well, that is the way he described it to you?

A. That is right.

Q. At that time he had numbness in the toes, didn't he?

A. On the 21st, yes.

Q. And he had severe pain?

A. Yes.

Q. They are two of the signs?

A. Yes.

Q. Did he have swelling?

A. Yes." (190)

The witness, notwithstanding his earlier statement to the effect that the inability to move the toes was one of the five signs of impairment of circulation which should be given independent consideration from the time of the operation, claimed later on in his statement that inability to move the toes was not an important sign until a couple of days after the operation. (R. 192)



Although it was the doctor's custom to visit the patient during the afternoon following the operation, in the instant case no visit was made until 10:45 in the evening, which the defendant admitted was a violation of his usual procedure. (R. 195)

The nursing record on 9:00 o'clock of the 21st noted that the patient's toes seemed quite red and somewhat swollen, and that the edges of the cast were snipped slightly to relieve pressure. (Ex. 1) (R. 196) *The witness admitted that if he had been there at 9:00 o'clock when the nurse made the observation in the record that he probably would have shown concern about the redness of the toes.* He believes that some doctor must have been there because the nurses ordinarily don't have authority to snip the cast without authorization from the doctor, and they don't ordinarily do it without notifying the doctor. (R. -96) The snipping of the cast would only have a local effect on relieving pressure on the toes and would not give any relief of impairment further up in the cast. (R. 197)

“Q. Did you make an examination at that time?

A. Yes.

Q. What did that examination disclose?

A. Increased swelling of the toes, and evident impairment of the circulation.

Q. Did you inquire about pain and things of that nature at that time?

A. Very probably.

Q. And you used the other tests that you have mentioned?

A. Yes.

Q. Now, will you describe — I take it that Doctor Lamb, however, split the cast?

A. Yes.

Q. Were you present while he did that?

A. Probably, because this was such a unique occurrence that more than likely I was there. I don't exactly recall.

Q. You don't actually split casts?

A. That is right.

Q. Even when there is an impairment of circulation?

A. As I indicated, there is always impairment. Whenever the impairment gets to the point where it will do harm unless the pressure is released, then we split it — always.

Q. Will you describe, if you can, the extent to which the cast was split? That is, the procedure done?

A. This is a circular cast, wrapped all the way around the leg or foot; it was split down the middle of the front from just below the knee out to the end of the cast. (R. 199)

The splitting of the cast, of course, did not expose the area of the incision. (R. 200) *Of course, necrosis was going on within the wound and the necrosis could have been affecting the nerves which helped to motivate the muscles and ligaments which have to do with the movement of the toes.* (R. 201 They used a spreader after splitting the cast to relieve the pressure. (R. 202) There was very little risk of disturbing the position of the bone while actually performing the operation of

spreading the cast. If the impairment of circulation is not relieved and if the blood is not permitted to carry nutrition to the area of the foot involved, necrosis would set in, and that necrosis could result in the destruction of nerves, muscles, and of course even bone itself. That process can be a rather insidious one. It can go on deep within the wound without being made apparent in an examination of the wound. (R. 203)

When asked if it was important to observe the patient's condition after the cast was split, the defendant answered yes, because it was important to determine if the impairment of circulation continued. When asked if he made such a determination, he said yes, but there was no record made of it. (R. 204)

“Q. The notation at 2:45: ‘Able to move toes a little better. States he can feel better in the toes.’ Is that correct?

A. I believe that is what it is, yes.

Q. Did you make an observation yourself in that regard?

A. Yes.

Q. I take it you talked to the patient about that?

A. Yes.

Q. And you felt his toes and asked him if he could feel it?

A. Yes.

Q. And he reported to you that there was some feeling there?

A. I don't recall what he said in regard to feeling. That is the nurse's note.

- Q. I am speaking of your personal examination.
- A. Well, I don't recall if he could wiggle his toes.
- Q. Were those facts important at that time?
- A. They were important, yes. And they were, just as in this full program, it is part of the material or the facts or evidence that we get together and weigh it all — the color, swelling, the fact that he could move it, the numbness — all of those things are weighed. There is no one of them of no importance, and no one of them of supreme importance. We bring them all together, weigh the information, and then determine in our course of action. And that was still true after splitting the cast.
- Q. And after weighing all of those facts you did split the cast?
- A. Yes.
- Q. Now, of course, Doctor Pemberton, all of those things didn't just happen all at once?
- A. That is right.
- Q. In other words, when you split that cast at 8:30, that wasn't the first time there was swelling and all of these signs of which you have spoken?
- A. That is true.
- Q. They had been developing since the time of the operation?
- A. Some of them. (R. 205-206)
- Q. Well, sometimes the necrosis spreads a little, doesn't it?
- A. Yes.
- Q. As a matter of fact, when necrosis occurs that in itself impedes circulation?

- A. That is true.
- Q. So that the necrotic area might enlarge?
- A. Yes, sir . . .
- Q. What would cause it to spread?
- A. Necrosis?
- Q. Yes.
- A. Infection.
- Q. Whenever necrosis occurs does infection always go along as a companion of necrosis?
- A. Infection in the necrotic area does go along with it, yes.
- Q. It does not necessarily become systemic?
- A. That is true.
- Q. Those two together can destroy nerves, as well as muscles, as well as soft tissue?
- A. Infection and necrosis, yes.
- Q. Now, one of the reasons, I think you said yesterday, for insuring an adequate blood supply after the performance of an operation, is that the richer the blood supply the less the likelihood of infection developing; is that true?
- A. Yes.
- Q. And the poorer the blood supply the greater the likelihood that infection may develop?
- A. That is relatively true.
- Q. That is one of the reasons, I take it, that you do have to elevate the foot and keep it in elevation, to facilitate circulation?
- A. Yes.

Q. To permit the gravity flow of the blood back through the veins?

A. That is right." (R. 207-208)

In describing the notation made at 6:00 o'clock p.m. on the hospital record on the 22nd by Dr. Cadillo to the effect that the toes appear to be cyanosed and swollen, the defendant defined the term cyanosed to mean trauma due to the slowing of the blood flow, and it is another term for blueness, and this indicated that some impairment was still going on after the splitting of the cast. (R. 209-210)

The regularity of hypos indicated that severe pain was continuing, notwithstanding the splitting of the cast. (R. 211)

*The positioning of the bones in a triple arthrodesis could be adjusted within two weeks after the operation is performed, when there are indications that it should be done, so that if by splitting the cast or movement of the patient's foot after the cast has been split there could be loss of position, there would still be time within a two-week period to make the adjustments with the expectation ordinarily of a good result. (R. 214)*

The notes made in the doctor's dictaphone report of examination on January 3, 1955, (Ex. 2) are significant.

" "This boy had his operation as planned on December 24, 1954. A triple arthrodesis was done. There was nothing unusual about the operation and his immediate post-operative convalescence was uneventful. However,

following the operation he has had no sensation, apparently, in any of his toes and has been unable to move the toes. There is a rather excessive amount of swelling of the forefoot and some bleb formation over the forefoot. He comes in today for the first dressing and change of cast. There is considerable hemorrhage into the skin along the wound and there will possibly be some breakdown of the wound edges, but that is not definitely evident today, so that the stitches are taken out and a new short leg cast was applied. He will come in again for observation in two weeks.' "

"Q. The fact that he had no sensation or movement of his toes, was that of any importance?

A. It was important enough that I did make a special note of it.

Q. But you didn't describe that as an exception?

A. I believe it could be considered so, and say that his progress was uneventful. Then I went on to describe this as being hard.

Q. Now, this bleb formation, was that caused by impairment of the circulation?

A. Probably.

Q. Just tell us in our language what it means.

A. A blister formed on top of the foot. You say did that impair circulation? For example, around a broken rib it occurs commonly. There is no excessive amount of skin there. It is rarely seen at locations where there is plenty of skin, but where the skin is tight fluid forms under the skin.

Q. How extensive was this condition?

A. It covered the top of the forefoot just back of the toes.

Q. Is that where you expected a sore to be in the anticipation of the swelling?

A. That is one of the areas.

Q. So that notwithstanding the padding placed there, there was sufficient impairment of circulation and swelling to compress the padding so as to cause a blister or blood formation?

A. Yes. (R. 218, 219)

Q. Would you describe that as uneventful?

A. Yes." (R. 218-219)

There was nothing to indicate that the bones were out of position when the first change of the cast was made on January 3rd. Although the defendant knew that if the breakdown of the wound continued it would necessitate an early removal of the cast. (R. 220)

The taking of x-ray studies might have been helpful in determining the position of the bones, but the defendant did not take any on this particular occasion, notwithstanding the fact that the cast had been previously split and the patient could have rolled over in bed and to some extent placed the bones out of position. (R. 221)

"Q. So when you have a case involving the splitting of the cast, do you consider it necessary to x-ray when you make the change of the cast after two weeks?

A. No.

Q. I see. Well then, you don't consider this danger of the bones getting out of position as a very real one, do you, Doctor?

A. Yes, it is a very real one.



Q. In the splitting of the cast?

A. Yes. Not so much in the splitting of the cast, but as the subsequent looseness within the cast when the swelling goes out.

Q. Well, I take it that when the patient had the cast split in this case there was no subsequent looseness of the cast of which you are aware?

A. That is right.

Q. Now, when you come to the decision to split the cast, you knew that if there is an excessive looseness or movement in bed or something else that will put those bones out of position, that at an appropriate time when the cast is changed you can make a correction?

A. That is right. Of course, you have to realize that there is the risk of the anesthetic. Every time we do something that requires the use of an anesthetic we again run that risk that was present at the first operation, to a certain degree.

Q. The patient survived the first risk real well?

A. That is right.

Q. In other words, there was nothing in your operative record which you keep yourself which indicated that he suffered any difficulty by virtue of having been given an anesthetic except the nausea that he had when he came out of it?

A. That is true." (R. 222-223)

\* \* \*

"Q. So as you were about to split that cast at 8:30 in the morning of the 22nd of December, on the basis of all of your previous experi-

ence, did you feel that there was a danger — and when I say 'danger' I mean a real danger — which would threaten the successfulness of that operation, by virtue of your splitting the cast?

A. Yes.

Q. But you didn't consider the danger as great as the danger of continuing the impairment of circulation?

A. That is true.

Q. The one thing could be later corrected if anything untoward occurred; the other might progressively become so bad as to actually result in destruction of limb itself if not corrected?

A. I think that would be stretching it a little bit, but certainly it would do damage.

Q. It would do more damage than was done?

A. Yes.

Q. Now, your records show, Doctor, that he returned to you on the 19th of January, and you say: 'This man's wound was broken down considerably and there is odor in the cast, so he came in to have the cast changed. The cast was removed and a new cast applied. He will come in again February 7th.' Is that correct?

A. That is right.

Q. Now, will you describe the nature of his wound at that time?

A. Those skin edges along the incision had shown differentiation and you could tell that the tissue was dead. It had no circulation whatsoever. It was dark in color and had

become infected, because dead tissue has no circulation and it always becomes infected, and had fallen apart so that the wound was lying open. So after retraction of the skin edges which were not as impaired as the underlying tissues, it showed the dead tissue underneath, leaving this ulcer that you speak about, with dead tissues on both sides of it and considerable discharge from it. As the tissue dies this healthy tissue beside it begins to pour out white blood cells — or the fighting mechanism of the blood — and this makes pus. It is fluid and white blood cells that were being discharged from the wound, and it was this dead tissue that developed an odor.

Q. Now, you continued to examine the patient as he came in on the dates indicated in your record up until July 27th, 1955, I take it?

A. The last time I saw him was July 20th.

Q. Would that be wrong here?

A. Yes, that is my associate, Doctor Chapman wrote that. That is his initials.

Q. So the last time you saw him was on the 20th?

A. That is right.

Q. And you changed the cast, do you recall how many times altogether?

A. I can check it.

Q. Will you do that?

A. Three times.

Q. Would you indicate the dates?

A. January 19th — No, four times.

Q. All right.

A. January 3, January 19, February 7, and February 19.

- Q. How long was he instructed to wear the cast after February 19th?
- A. I would have to see my record again. Until March 3rd, when it was removed.
- Q. Did you take any x-rays at all during this period?
- A. Do you mean up to July 20th?
- Q. Up to the time you removed the cast?
- A. No.
- Q. Do you usually take x-rays at all during the post-operative situation?
- A. Not while the cast is on." (R. 223, 224, 225, 226)

He took the first x-ray on July 12th. Although he had three times previously removed the cast, the last removal occurring on March 3rd. (R. 226) The x-ray taken July 12, 1955 (Ex. 3), after removal of the final cast, shows that the cuboid bone has dropped almost an eighth of an inch to the bottom of the foot. It was supposed to unite at that point, but it has not united, so that the operation so far as the cuboid-calcaneus joint is concerned was unsuccessful and produced a poor result. (R. 228)

The falling of the cuboid bone caused a protrusion into the sole of the foot, which resulted in the formation of an ulcer upon weight bearing. (R. 229) The defendant, after examining the plaintiff's foot in the courtroom, was not prepared to say whether corrective surgical procedure would be desirable.

The patient was first instructed to bear weight on his foot on March 19th. (R. 234) No x-rays were taken on March 19th to determine whether the cuboid bone was in position or not.

“Q. But you felt at that time, at any rate, that it was safe for him to start bearing weight on the foot?

A. At that time I was quite definite in my own mind that there was nothing to lose, after it lost its position. There was no question but that the cuboid was down in the sole of the foot. There was nothing to lose; he was going to have to have further surgery if he were going to have a good foot.

Q. *In other words, at the time you told him to start weight-bearing the cuboid bone had already fallen?*

A. Yes.

Q. And that appeared discernible upon examination without the benefit of x-rays?

A. Yes.

Q. You did that by palpation of the foot with your hand, I take it?

A. Yes.

Q. You anticipated at that time, I take it, that through putting weight-bearing on his foot, that would be the cause of callus to the bottom of his foot?

A. I would have anticipated callus, yes.” (R. 231)  
bone occurred sometime bet

*The doctor believed that the falling of the cuboid bone occurred sometime between early in January and*

*the early part of March.* (And yet on two subsequent occasions the cast was changed without the taking of x-ray which would establish the actual time the bone dropped.) (R. 244-245)

On re-direct examination, Dr. Pemberton testified as follows:

“Q. You knew, of course, that in triple arthrodesis there is considerable swelling which follows?

A. Yes.

Q. And later it eventuated that the swelling was such as to accomplish a restriction of the circulation?

A. Yes . . .

Q. Of course, you have no way of determining how much swelling will occur?

A. That is right.

Q. You know there will be considerable swelling, swelling when the arthrodesis is completed?

A. Yes.

Q. And that that swelling will commence almost immediately after the operation is completed?

A. That is true.

Q. And that swelling will have a tendency to increase up to a certain point?

A. That is true.

Q. And if the swelling is such that it develops into a restriction of the circulation it will have a tendency to continue to increase, isn't that correct?

- A. If it can not be relieved at that point, where it cuts off this further circulation distally, yes.
- Q. So that I think you testified on the first day that the impairment of circulation has a tendency to promote itself?
- A. That is true after a certain point.
- Q. In other words, the impairment shuts off the return of the blood, so the blood remains there, and more blood is pumped in and that makes for more swelling?
- A. That is right.
- Q. And then when the swelling becomes greater and compresses the padding which is there, up against the inner wall of the cast, then that increases the interference with the circulation?
- A. Yes.
- Q. And that can go on, and on, and on, until it can become a very disastrous situation if not corrected?
- A. Yes." (R. 256-257-258)

Dr. A. M. Okleberry, an orthopedic surgeon residing in Salt Lake City, testified that he performed surgery to correct the callous formation on the bottom of the plaintiff's foot caused by the fallen cuboid bone. The operation was performed August 26, 1955. (R. 249) He noted previous loss of soft tissue from the plaintiff's foot and clawing of the toes. (R. 250)

Assuming that there had been a successful triple arthrodesis performed on plaintiff's foot, he would still suffer about a 20% disability. Such an operation results

in loss of side motion of the foot, which is not a very great disability, such as the loss of an up and down motion would be. The plaintiff's foot was probably disabled about 30% taking everything into consideration. (R. 251) Dr. Okleberry did not recommend corrective procedure. (R. 252)

## STATEMENT OF POINT UPON WHICH APPELLANT RELIES

*There was ample evidence to justify the submission of the negligence of the defendant to the jury, and the court erred in granting a motion for involuntary dismissal with prejudice.*

## ARGUMENT

Inasmuch as the court's order in granting the involuntary non suit of the plaintiff attacks the sufficiency of the evidence to justify submission of the case to the jury, we have heretofore set forth in the statement of facts an extensive summary of the evidence from which it clearly appears that the defendant was negligent in applying too tight a cast to the plaintiff's left lower extremity during the arthrodesis operation. The defendant was further negligent in failing to promptly split or remove the cast in order to prevent the development of necrosis or tissue death because of impairment of circulation, notwithstanding the fact that the five cardinal symptoms of impairment of circulation began to manifest themselves on the day of the operation and continued to increase. All of these symptoms of impairment of circulation remained throughout the stay in the hospital



both before and after the cast was finally split at 8:30 in the morning on December 22nd. Even after the cast was split the plaintiff's symptoms indicated a continuing impairment of circulation with resultant necrosis.

The day following the splitting of the cast the toes were observed by the intern to be dark, cyanosed and swollen. The plaintiff continued to have severe pain, requiring numerous hypos right up to the time of his discharge from the hospital when his toes still remained swollen and discolored, and he was unable to move them very much. (Ex. 1) When the cast was finally taken off on January 3rd, the whole foot looked awfully dark in color. (R. 40) At home after leaving the hospital, he suffered a lot of severe pain, required pain pills every night so that he could sleep and was given pain pills during the day. (R. 85-86)

Of course, we could for emphasis restate all of the evidence contained in the statement of facts in addition to show this negligence. There isn't any doubt but what the initial cast was placed on too tight with inadequate padding. The defendant admitted that the impairment of circulation in this case continued from the time of the operation until the actual splitting of the cast two days after the operation. (R. 178) The defendant admitted to the plaintiff's father that the complication that developed from the operation, the unsatisfactory condition, could be the result of the cast being placed on the leg too tight. (R. 104, 47) This statement was never denied by the defendant. The defendant admitted that when the initial impairment occurs because of excessive swelling

or inadequate padding the impairment would have a tendency to become worse. (R. 121) That after three hours of impairment the tissue death begins to occur. (R. 122) That an adequate blood supply is necessary for healing and an adequate blood supply is necessary to prevent infection. (R. 128) That tissues will most certainly die if they are deprived of a sufficient supply of blood. (R. 129) That extensive swelling is expected in triple arthrodesis operation, and that is the reason for using padding before applying the cast. (R. 132) The defendant testified that a careful post-operative examination is important until the cast is actually removed. That it is necessary to determine from various signs and symptoms whether the defendant's judgment in the amount of padding used was right, and yet according to the hospital record the plaintiff was not seen by the doctor after the operation was performed in the morning until 10:45 that night, notwithstanding his continual complaints of severe pain. The nurse's record did not show another visit by the doctor until December 22nd at 6:30 a.m. (Ex. 1)

Dr. Lamb split the cast at 8:30 a.m. on December 22nd to relieve the pressure, but the nurse's record shows no visit after that until 7:00 a.m. on December 23rd, notwithstanding a notation in the record at 6:00 on the evening of the previous day that the toes appeared cyanosed and swollen. The next visit was on the day of discharge, December 24, after 6:00 a.m., and even though the defendant then noted that there was still swelling in the toes and discoloration remained about the same, and that he was unable to move the toes, there was no

effort made by the defendant to follow up on the operation until January 3rd, at which time the cast was removed and the doctor described an excessive amount of swelling of the forefoot with bleb formation over the foot. (Ex. 2) Yet when asked if the symptoms of impairment of circulation were present the doctor could wait until the next day to take another look, the defendant stated no, the patient would be checked again in the afternoon. (R. 171) The defendant even admitted that failure to visit during the afternoon following the operation until 10:45 p.m. was a violation of his usual procedure. (R. 195)

Certainly upon releasing the patient from the hospital with all of the symptoms of impairment of circulation staring him in the face, it was negligent for him to refrain from contacting the patient again for a period of ten days. The doctor admitted that on the occasion of his visit on the morning of the splitting of the cast there was "increased swelling of the toes and *evident* impairment of the circulation." (R. 199) The doctor admitted that necrosis was going on within the wound and could have been affecting the nerves which have to do with the movement of the toes. (R. 201) And the doctor admitted that it was important to note if impairment of circulation continued after the splitting of the cast. (R. 204) The doctor admitted that when the cast was split at 8:30 that wasn't the first time there was swelling and all of the signs of impairment, but that some of them had been developing since the time of the operation. (R. 206) The doctor admitted that there was some impairment still going on after the splitting of the cast.

(R. 209, 210) The regularity of hypos indicated that severe pain was continuing notwithstanding the splitting of the cast. (R. 211) The cast could easily have been removed completely long before January 3rd to relieve this impairment of circulation, and there would still be time within a two week period to make adjustments with the expectation ordinarily of a good result. (R. 214) The doctor admitted that the bleb formation was caused by impairment of circulation and this covered the top of the forefoot back of the toes, so that notwithstanding the padding placed there there was sufficient impairment of circulation and swelling to compress the padding so as to cause a blister or bleb formation. (R. 219) Of course, subsequent to January 3rd, when the cast was first changed on the various other trips plaintiff made to the defendant's office, the evidence of impairment of circulation, the strong odor indicating infection, the necrosis of tissue, were all manifesting themselves. (R. 223, 224, 225, 226)

The doctor stated that the cuboid bone dropped into the bottom the foot about one-eighth of an inch and the operation in that respect was unsuccessful and produced a poor result. (R. 228) At that time he told the plaintiff to start to bear weight on his foot, the defendant already knew that the bone in the foot had fallen out of position. (R. 231) As a matter of fact, the doctor believed that the falling of the cuboid bone occurred sometime between "early in January and the early part of March." No explanation was given for his failure to take x-rays during that period of time to determine whether the bone was in position or not. He apparently

preferred to remain in the dark on this point until sometime in March when it was confirmed by palpation. The doctor also admitted that the swelling in this case accomplished a restriction of circulation. That it commenced almost immediately after the operation was completed and that it had a tendency to increase and that after it increased it would have a further tendency to promote itself and that that situation could go on and on until a very disastrous situation would result if not corrected. (R. 256, 257, 258) Of course, in this case a disastrous situation did eventuate. The plaintiff suffered disability in his foot, loss of union in the joint involving the cuboid bone, loss of soft tissue from his foot, and clawing of the toes. (R. 249-252 inc.)

The entire record discloses gross negligence on the part of the defendant, measured by the standards established by his own testimony, although it is common knowledge within the experience of each and all of us that uncorrected impairment of circulation will result in damage to the cells of the body deprived of the nutrition supplied by the blood. An uncorrected impairment of circulation will progressively tend to promote itself and result in necrosis or death of tissue within three hours, and the symptoms thereof were clearly discernible for a couple of days and after admitting that all these conditions were going on, the defendant failed to do anything about it until 8:30 a.m. on the third day following the operation, and then all he did was split the cast without removing it, although he still observed that the impairment was continuing; and he discharged the plaintiff from the hospital and didn't bother to see him again for

a period of ten days, while this impairment of circulation which tends to promote itself was still continuing.

Even considering the record in the light most favorable to the defendant, there is no justification for the treatment or lack of it given the plaintiff in this case. It may be true that the doctor is a very busy doctor (he performed three bone surgery operations in one morning between 7:45 and 10:30 a.m. R. 156), but this does not relieve him of the responsibility of exercising ordinary care in the plaintiff's case; and it doesn't require a parade of reluctant orthopedic surgeons into the courtroom to establish that his treatment of the plaintiff in this case fell far below the standard of orthopedic practice in Salt Lake City. The plaintiff knew all of the symptoms of impairment of circulation. He had performed numerous similar operations. He knew that necrosis was the inevitable result of impairment of circulation. He knew that a close follow up was required because swelling is always expected in all arthrodesis cases. He knew that time was of the essence (necrosis sets in within three hours after the blood supply is impaired). He knew that the blood supply was impaired and that that impairment began at the moment that the operation was completed. He believed that the positioning of the bones in the foot was lost sometime early in January (he didn't know how early and apparently wasn't interested in finding out by x-ray or otherwise), and yet he knew that if positioning was lost there was still plenty of time to correct it within two weeks following the initial positioning of the bones, with the reason-

able expectation of a good result. Certainly it is apparent that the defendant has condemned himself with gross negligence with the resulting serious permanent injury to his patient.

In the case of *Daiker v. Martin* (Iowa) 91 N.W. 2d 747, there was a dearth of medical testimony, and it appeared from the testimony that the case involved the application of a cast so tight that it prevented circulation of blood in the lower leg and foot resulting in infection and subsequent amputation of the foot. The trial court rendered a judgment on a direct verdict for the defendant. In that case the same symptoms of impairment of circulation were present and there was a splitting of the cast with the conditions of impairment continuing notwithstanding the splitting of the cast, although there was a temporary relief from pressure. The leg was placed in a cast on November 4th. The cast was split at 3:00 p.m. on the same day. At 6:00 p.m. it was split a bit further. The cast was changed on November 25th, and again on December and February 1st following. During all of this time the patient in that case indicated symptoms comparable to the case at bar. The decision cites many other cases holding similarly. We quote from page 752:

“In the case at bar the record shows defendant partially split the cast three times but there is evidence indicating these loosenings were not sufficient and that thereafter defendant knew the leg was swelling inside the cast and causing pain, but failed to loosen the cast. There is also evidence plaintiff was given drugs to relieve the pain. Dr. Newman testified one of the dangers

of such procedure is that the actual seat of the trouble causing the pain might be masked. He testified the best protection for any infection or healing is good blood supply and a cast that impaired the circulation should be split. He testified also that when he first examined plaintiff (shortly after plaintiff's second confinement in St. Anthony hospital under defendant's care) there was no perceptible blood supply in the foot, there was complete anesthesia in the forward half of it, and in the foot were pus pockets, sores, dead tissue, etc.

"Lundgren v. Minty, 64 S.D. 217, 266 N.W. 145, supra, is factually similar to the case at bar. One difference is that in the case at bar the record does not show infection in plaintiff's leg when the bones were set nor any opening through which infection could enter from the outside. In the case at bar there was evidence such a fracture could impair the circulation. In the cited case there was evidence infection destroyed a wall of an artery and did impair the circulation. Here, as there, the question of defendant's negligence was one of fact rather than medical theory or expert opinion and was for the jury to determine."

The case of *Lundgren v. Minty*, 266 N.W. 145, also involved the application of a cast so tight that it could be inferred from the evidence that circulation was impaired with resultant damage to the lower extremity, eventually requiring amputation. We quote commencing at page 148:

"It is respondent's theory of the case, on the other hand, that the circulation in the foot was impaired because of the fact that the first and second plaster casts placed upon his leg were too tight. He says that he constantly complained to



appellant about this condition, but that appellant failed to remedy it . . . That he complained to the nurses and to the doctor that the cast was too tight, that his toes commenced to be swollen and discolored, and painful, and that a sore or ulcer opened on his heel. He says that portions of the first cast were cut away from time to time, and that, as this was done, the pressure seemed to be relieved and his foot felt and looked better, and that during the period from July 15th to 20th, when no cast was on his leg, the condition of his foot very markedly and noticeably improved and the ulcer on his heel practically healed up.

“. . . The treatment in this case was for a fracture a little below the knee. Gangrenous destruction of the foot is not a normal or usual result from such a fracture. It is a result that might very well follow if the cast were permitted to be or remained so tight as to unduly restrict circulation to the foot. Certainly where, as here, the toes were at all times observable, to permit a cast to remain so tight would be either unskillful or negligent or both . . . On the whole record in this case, we think it was for the jury to determine whether the gangrenous destruction of the foot resulted from impairment of circulation by reason of the breaking down of the artery for which appellant would not be responsible, or whether it resulted from appellant's lack of skill or care, or both, in encasing the leg in casts too tightly applied and maintained for which, of course, he would be responsible.”

In that case there was testimony of a doctor to the effect that a cast unduly tight and impairing circulation could cause the condition that he found, but the court said:

“... Indeed, that is hardly a matter requiring expert opinion. Even the laymen is familiar in a general way with what happens when the circulation of blood to any member of the body is seriously impaired by external pressure continued for any length of time.”

Of course, in the case at bar there is ample medical evidence provided by the defendant himself to show the casual connection between the tightness of the cast and the damage to plaintiff's foot. As a matter of fact, the defendant admitted to the father in the hearing of the plaintiff that the complications could have been caused by the cast being place on too tight.

To the same effect is *Van Der Bie v. Kools*, 264 Mich. 468, 250 N.W. 269; *Bartholomew v. Butts*, 232 Iowa 776, 5 N. W. 2d 7; *Longfellow v. Vernon*, 57 Ind. App. 611, 105 N.E. 178; *Prather v. Downs*, 164 Wash. 427, 2 P2d 709; *Norden v. Hartman*, (Calif.) 285 P2d 977; *Lewis v. Johnson*, (Calif.) 86 P2d 99.

In the very recent case of *Atkins v. Humes*, (1959) (Fla.) 110 So. 2nd 663, involving the negligent treatment of a fractured arm, it was held that the jury could base a finding of negligence upon the principle of common knowledge and experience, and that no expert testimony was necessary, and the case certainly follows a common sense rule. Everyone, at least from the age of a boy scout and upwards, knows that when a condition exists which causes the shutting off of blood supply that serious trouble is going to develop unless that condition is promptly eliminated.

## CONCLUSION

In this case the plaintiff was seriously and permanently crippled because of the negligent treatment of his left foot by the defendant. The testimony of the lay witnesses was fully substantiated by the hospital record (Ex. 1)

Although the defendant was skillful and evasive in his testimony, he established by the words of his own mouth the standard of orthopedic practice in Salt Lake from which the record shows he deviated. He knew the five cardinal signs of impairment of circulation. He knew that unless the impairment of circulation was relieved within two to three hours that necrosis and infection would set in with the resultant injury and disability to the plaintiff's left foot. Yet he waited until 8:30 on the morning of the third day after the operation to split the cast to relieve pressure, and then, observing that the splitting of the cast did not eliminate the symptoms of continuing impairment, he discharged the plaintiff from the hospital with instructions to contact him in a couple of weeks, and made no attempt in the interim to follow his condition. Knowing that the plaintiff's bones may have lost position after the splitting of the cast, he took no x-ray on January 3rd when the cast was removed, and yet at that time, by his own testimony, if there had been a loss of positioning it could have been corrected, and when later asked when the cuboid bone dropped out of position the best information he could give was that it could have been sometime between *early* in January and March. Certainly the undisputed evidence clearly

shows gross negligence on the part of the defendant which resulted in the plaintiff's serious injury and disability.

We respectfully urge this court to reverse the judgment of the trial court.

Respectfully submitted,

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Appellant*